

CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

SIGNIFICANT NEONATAL HX	DOB	WEIGHT	HEIGHT	PKU
DATE OF VISIT				
AGE				
WEIGHT				
HEIGHT				
HEAD CIRCUMFERENCE				
SUBJECTIVE (HISTORY)				
1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 2. ELIMINATION 3. GROWTH AND DEVELOPMENT 4. PARENTAL CONCERNS				
OBJECTIVE PHYSICAL EXAM				
NUTRITION				
HEAD/FONTANEL				
EENT				
NECK/CLAVICLES				
LUNGS				
HEART				
ABDOMEN				
GENITALIA/HERNIA				
HIPS/SPINE				
EXTREMITIES				
SKIN				
NEUROLOGICAL				
ASSESSMENT				
PLANS AND COUNSELING				
SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT				
	EXAMINED BY		EXAMINED BY	
PATIENT's IDENTIFICATION. (Name, last, first, middle, grade, date, hospital or medical facility)		REMARKS		

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